These are my comments related to the specific questions in the white paper :

a. The number of Statewide MCOs should be severely limited. More MCOs equals more paperwork and confusion. I would recommend the traditional and only one more. Then energy could be shifted toward making that "private" one effective, but still gives patients a choice.
b. Limiting the number of MCOs would reduce the paperwork/complexity. All Medicaid providers should be given a link to "choosing wisely. " They can know that if they step outside these guidelines, they can be expected to need to justify procedures that are not appropriate or not be compensated. I was impressed that Medicaid put out the bulletin that they would not cover strep/flu testing on the same day. I had been fighting that in the urgent care related to my own institution. My feeling was that if someone did not know the difference in flu & strep, they should not be in primary care, much less urgent care. More bulletins like this could be put out. Like not reimbursing for PAP in someone who had hysterectomy for benign reasons. If practitioners know they won't be paid, they won't order inappropriate tests.
c. There are almost no specialty services for any MCOs. They claim to have these, but if the patient calls, they are told either that that specialist was never in the network or the specialist is not taking any more Medicaid patients. Physical Therapy simply does not exist. MCOs claim to have this, but it can be a 9 month wait. Likewise, I can get a patient in to Neurology/Neurosurgery, but they must wait as much as a year and they must go to New Orleans from Baton Rouge for access. There is no pain management.
    a. There must be a transparent reporting of the number of visits that the patients have to specialists. The MCOs should not be allowed to simply list specialists that in fact are not accessible.
    b. Patients need a direct line to the CEOs of any MCO as well as a direct line to someone at DHH who can then monitor whether the service was actually provided.
    c. Providers need a direct line to the CEOs and DHH related to any problems with specialty access. Providers should have both a phone and email addresses.
    d. All complaints should go to both the CEO and to DHH
    e. A direct line would provide input about an immediate problem.
    f. Annual surveys are only worth doing if they ask good questions. They should aid with the immediate input to the direct line suggested above.
    g. Practitioners & patients should have an input into the surveys. The surveys should always have an opportunity to make a comment about any multiple choice question as well as a place to make general comments.
d. One of the biggest issues related to timely access to care is transportation
    a. The underserved often do not have vehicles
    b. Yes, there is transport available, but this requires 48 hour scheduling
    c. There is no capacity to get someone who is sick today in for a visit
    d. There is no capacity to transport someone who came on transportation and needs hospital admit to the hospital unless EMS is called (or the Lake pays for a cab)
    e. Patients get carted all over town by these transport services as the services picks up people and delivers them everywhere
    f. There should be a centralized scheduling system where patients call one number for any transportation. All the various companies could be scheduled through this.

g. That system should be on a computer system, so patients from one area going to a place in a given area might all be picked up and someone going from the Siegen area to a visit on Essen is not taken downtown before they get to their appointment. I know this happens because I utilized Medical transportation once when I needed PT and my spouse was working and would have needed to take off two weeks for me to get the post op PT. I was scheduled for a 9 am appointment on day one. The appointment was on Essen and I live off Stumberg, which should be about a 15 minute ride. The van arrived at 6:45. After my appointment, I called transportation. More than an hour later I was picked up. Then I was driven downtown including past the health unit before I was finally taken back home. A computer system could avoid this absurdity. Probably save the companies money & provide more patient satisfaction. T
h. The system needs to incorporate urgent same day visits. I have one patient who regularly has COPD exacerbations. She can't get here. So I give the meds and she follows up with me in a couple days when she has transportation. If I don't treat over the phone –OMG how awful—she universally ends up in the ER. A far more expensive proposition.

e. At LSU Mid City, we have developed a behavioral health program where a Social Worker with extra training in psychology sees patients who are positive on the PHQ9 questionnaire. She evaluates the patients and then consults with the LSU staff psychiatrist. The psychiatrist then sends recommendations for medication adjustment if appropriate. The Social Worker continues to see the patient to help them with their psychological problems. A similar system might be worked out where multiple physicians have a single Social Worker similarly trained to whom they can refer patients. The social worker then could have direct access to a single psychiatrist who would be paid for the consulting services.
f. A concern with the capitation issue is that the payment per patient would actually be commensurate with the gravity of the health issue of many Medicaid patients. Many of them are playing catch up with their medical care, receiving it for the first time in their lives. Others are struggling with the effects of poverty on their health. Capitation could be very risky financially for the practitioner. Pay for performance is likewise problematic. Many ill-informed patients simply refuse to have a colonoscopy. They refuse vaccines. I have one with a very high A1c who is refusing any form of injectable medicine. When they have unfounded beliefs, it is tough to get past their concerns, no matter how dedicated the physician is. There needs to be some opportunity for the practitioner to state that the patient refuses proper treatment. Or the patient is on drugs or has other mental issues that are interfering with reaching goals. I have a patient with early dementia who is uncontrollable by her family. She eats what she wants when the family is not present and gets up in the middle of the night and eats whatever she wants. Her A1c is 11. Nothing the family can do except put her in a nursing home, which they will not do. My PFP should not be judged badly in this situation. I need an opportunity to express the specific problems. If there really were a way for the MCO to help here, that would be great. But in certain cases, unless someone lives with the patient, there is no controlling the behavior.
g. I am not sure what "requirements" should be made of the MCOs, but I have some suggestions for improving population health.
    a. A lot of the Medicaid population goes to church, often on Wednesdays AND Sundays. Efforts could be made to engage the churches in healthy behaviors. Church dinners

could be encouraged to be points where patients can learn to eat better, rather than constantly serving standard LA fare (mac & cheese, fried foods, vegetables in pork fat, etc.

b. The MCOs could work with BREC & places like the Butler Center to get their patients into meaningful exercise. MCOs could provide exercise videos for the patients. I give out the NIH "Go4Life" which is an excellent video for sedentary or disabled patients. It is free and can be copied with no copyright restrictions.
c. The MCOs could work with various gyms, such as the Y to provide access for their patients.
d. The MCOs should work with nutritionists to help patients learn to eat.
e. The MCOs should be required to provide Rx for nicotine replacements including gum and lozenges, not just patches. Also, Chantix should be on the formulary.
f. Patients should be strongly supported by the MCOs in behavior issues related to smoking, obesity and sedentary lifestyle.
g. Consider outreach to barbershops and beauty shops. This was done effectively for HTN (Victor R et al, ACC 2018—referenced in Family Practice news April 1, 2018)

h. In general, I find that the care management from the MCOs is intrusive and unhelpful.
    a. There needs to be meaningful input if it is going to exist
    b. I don't need someone to go to evaluate a patient, send a 10 page report that includes information such as among the patient's issues is that they wear glasses, but the person who did the exam failed to notice that the patient has a glass eye!
    c. I think it would be helpful if the MCO asked the provider to introduce the idea that MCO would be sending someone out to see them. Patients may not want this.
    d. We also find it odd that companies will ask us to send medical records. Don't they have access to this?
    e. Rather than going out and doing an evaluation of patients and telling us details of their health that I already know and creating extensive pages of documentation, the MCOs should reach out to the patients regarding behaviors—diet, exercise, smoking.
        i. Figure out ways to help the patient get started exercising.
        ii. Evaluate the 48 hour diet recollection and help the patients understand the concept of "empty calories." ("I don't eat that much." But they don't eat anything that has nutritional value).
        iii. Get the patient into meaningful smoking cessation programs. Provide all forms of nicotine replacement for them
        iv. Have a coach call them for these efforts.
            1. How many cigarettes today?
            2. Did you stop smoking in your house
            3. How much are your cigarettes costing you? How much have you saved since you started trying to quit
            4. What vegetables did you eat today/ yesterday?
            5. Did you get at least 15 minutes of dedicated exercise—what was it?
    f. Patients should not be allowed to get services from more than one primary care provider unless their assigned provider sends them.
        i. There are reasons to send to different primary care providers

        ii. One example is that I do joint injections that other providers in my group don't do
        iii. Another example is that I used to do the Asthma Clinic for EKL. I know a lot about this that some of the other providers do not know. They don't need to see a pulmonologist.
        iv. Another example is if an NP needs advice & assistance from a primary care in areas they aren't comfortable with. The NP may not need to send the patient to a specialist first. My experience is that NPs are very quick to seek specialists without consulting their supervising MD.
    g. The result of any test/ lab done by a specialist must be send to the primary care.
    h. All specialists must send a copy of the visit to the primary care.
i. Perhaps developing procedures for group visits could help incentivize healthy behavior and compliance.
    a. I was able to do this with the asthma program at EKL
    b. MCOs could develop group visit programs for chronic diseases and then educate providers on how to implement these
        i. Group visits could include education about exercise and nutrition
        ii. That is not something most providers have a lot of time for, but with assistance in group visits, perhaps we could get at THE underlying issue related to most of our chronic medical problems which is obesity/ sedentary lifestyle
j. I support making the approval processes transparent. All the MCOs should have the same requirements for specific tests and these need to be laid out to the providers
    a. Again, practitioners and patients need a direct line to the MCO and DHH to address complaints.
    b. End of year surveys suffer from patients and providers forgetting about what happened throughout the year
    c. I agree with the idea of having providers and stakeholders on the governing boards. These should be rotating for a period of not more than 2 years (or even 1 year) so that the board is not perpetually hearing from the same satisfied provider.

The following are some additional comments related to my experience with Medicaid:

I have no sense that any MCO has helped me manage any patient. My interaction is "request, deny, argue." I feel that the MCO exists to say "no," and act as a detour sign to patient care.

I get a lot of useless information from the MCOs.

I would like transparency in terms of getting the data that shows that the MCOs have saved anyone any money.

I believe there is inadequate input from both provider and patient related to their satisfaction with the MCOs. Input needs to be direct and immediate, not just limited to useless end of year surveys that just ask for a score rather than real information.

Practitioners should not be "dinged" when patients fail to get mammograms, PAPs, colonoscopies when they either no show repeatedly or simply refuse to do these. There needs to be a "refused" column. For some patients, these refusals are close to religious beliefs.